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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

BERTHA GARELICK, *et al.*,

Petitioners,

VS.

DONNA E. SHALALA, Secretary of the U.S. Department of Health and Human Services, and WILLIAM TOBY, Administrator, Health Care Financing Administration,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

PETITIONERS' REPLY BRIEF

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A. *Respondents' Concessions*

Respondents' brief (Resp. Br.) makes several important concessions:

1. The 1989 Medicare fee cap statute is an exercise of the police power for the *public good* (Resp. Br. p. 8) putting this case squarely in the posture of anesthesiologists being forced to pay to ameliorate a social problem which they did not create. The rationale of Justice Scalia's separate opinion in *Pennell v. San Jose*, 485 U.S. 1, 15 (1988) therefore would apply if accepted by other members of the Court.

2. The source of the compulsion to treat all Medicare cases originates under state law and professional ethics and therefore presents a *novel* question of constitutional law. (Resp. Br. p. 7.)

3. Each of these concessions demonstrates why the Court should grant certiorari in this case. On top of these is the Court's recent decision in *Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust For Southern California*, 113 S.Ct. 2264 (1993) which respondents apparently believe overruled the long-standing takings clause rule in public utility cases. The applicability of the holding in *Concrete Pipe* to regulation of rates chargeable for compulsory services therefore demands further refinement and clarification and this is the case in which to do it.

B. *Respondents' Factual Oversights*

The arguments in respondents' brief are primarily theoretical and written in the abstract – far removed from the factual realities of this case. They overlook or misconstrue the following facts, which when properly understood compel a different conclusion:

1. This case relates solely to anesthesiologists, who are key members of every major surgical team. Anesthesiologists do not function independently but as part of the life-support system in hospital operating rooms. In many cases, the success of a surgical procedure (e.g., open heart surgery) depends on the anesthesiologist's monitoring of vital signs and availability to respond immediately to emergencies as they arise on the operating table.

2. Anesthesiologists have no choice in the patients they treat. They may not refuse to care for a patient because he or she is on Medicare. This was the existing situation *before* the Medicare statute was first enacted in 1965 and was the situation when the challenged fee cap was enacted in 1989. This is not the case of *subsequent* state government action[1] or professional

[1] The New York State "Patients Bill of Rights" adopted in 1977 was intended merely to codify existing standards.

requirement.[2] It has always been the case. Congress enacted the Medicare balanced billing fee cap in the face of an existing compulsion, which was part of the factual context for the statute, and necessarily incorporated in the statute's premise. It cannot be separated out in isolation as the Court of Appeals and respondents have done.

3. The New York State statute requiring hospitals to treat all patients alike regardless of source of payment does not exist in a vacuum. It cannot be implemented by the hospital alone. The medical staff is part of the hospital, and the attending anesthesiologists are subject to the hospital's control and discipline. If a staff doctor refuses to comply with the hospital's legal obligations he or she is subject to loss of hospital staff privileges.

4. The Medicare fee cap at issue here is *not* the amount to be paid by the Federal Government, but is the amount to be paid by the patient, without regard to income or available resources. It applies equally to millionaires and to paupers.

5. The loss of income to anesthesiologists is substantial. The usual and customary market rates charged by petitioners in this case to non-Medicare patients was $70 per 15-minute unit, compared to $19.99 for Medicare beneficiaries, *including* the 115% fee cap. (*See* record in courts below.)

6. New physicians choosing the field of anesthesiology must invest tens of thousands of dollars in their education — the median cost for four years medical training for all doctors is expected to be $79,160 for the class of 1995. New physicians emerge from medical school with an average student loan indebtedness of $50,000. (*Newsweek*, April 5, 1993, p. 31.)

7. Anesthesiologists do not "collect 15% more than their colleagues who accept assignment of Medicare claims" (Resp. Br. p. 11). The "colleagues" of anesthesiologists are other anesthesiologists, who rarely accept assignment, and surgeons

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[2] The anesthesiologists' ethical obligation to treat all patients equally was first codified in 1985, but again reflected existing standards.

(who are free to refuse Medicare cases). Most of the physicians who accept assignment in Medicare cases are internists, family doctors and other office practitioners who are able to streamline their office procedures to realize a reasonable income from a large number of small Medicare payments, sometimes supplemented by laboratory tests and other income-generating extras. These are not the true "colleagues" of operating room anesthesiologists, who do not see office patients but instead are assigned to operating rooms where they *must* treat every patient who comes along – including cases which come up when they are on 24-hour emergency call.

C. *Question Presented*

The question presented on this appeal is not as stated in Respondents' Brief (p. I):

> Whether 42 U.S.C. 1395w-4(g), which limits the fees physicians may charge Medicare beneficiaries, results in a taking of private property without just compensation, in violation of the Fifth Amendment.

Rather it is whether the statute results in an unconstitutional taking *when applied to anesthesiologists*, who may not refuse to treat Medicare beneficiaries.

Petitioners recognize the prior holdings that Medicare fee limits are constitutional for doctors who are free to refuse to treat Medicare beneficiaries. But what of those who are not?

This is not a grab for more money – it is a plea for fairness. Most anesthesiologists are perfectly willing to lower their fees for patients of limited means, but why should they be required to take a cut for millionaire patients who happen to be enrolled in Medicare? This is not a question of Medicare paying for the service (as in "assigned" cases), but rather of the patient paying the difference between the Medicare allowance and the fair market value. Why should Congress mulct the doctor to help the rich?

When a federal statute requires a doctor *who has no choice* to accept a deep cut in his fee from a wealthy patient, there is a constitutional obligation to correct the inequity.

The Constitution is *not* money-blind.

ARGUMENT

Respondents incorrectly cite *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986 (1984), in support of their suggestion that petitioners have no property interest in receiving "a particular rate of return on whatever resources they have invested in their professional education and training." (Resp. Br. 8.)

Petitioners assert a property interest in their performance of medical services. It cannot be disputed that anesthesiologists and other licensed physicians have a right under state law to render such services and collect fees. Petitioners' services thus fully meet the definition of protected property interest set down in *Ruckelshaus*. (467 U.S. at 1001.) What petitioners seek as compensation for this property is the market rate, in accordance with settled takings clause jurisprudence. (*See U.S. v. Fifty Acres of Land*, 469 U.S. 24, 25-26 (1984).)

The significance of petitioners' investment in education and training, in contrast to the nursing home owners in *Minnesota Association of Health Care Facilities v. Minnesota Department of Public Welfare*, 742 F.2d 442 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985), is that petitioners' investment will be *totally* destroyed if they withdraw from practice. (Pet. 12-13, n. 6.)

Respondents rely heavily on the decision in *Connolly v. Pension Benefit Guarantee Corp.*, 475 U.S. 211, 225 (1986) to support their argument that the Medicare fee caps do not effect a taking of petitioners' property. (Resp. Br. 8-9.) *Connolly*, however, does not stand for the proposition that Congress may interfere with private economic interests in any manner it deems fit, in order to "adjust the benefits and burdens of public life." *Cf.*, *Connolly*, 475 U.S. at 229 (". . . the Court has never intimated that Congress possesses unlimited power to readjust rights and burdens and upset otherwise settled expectations." (O'Connor, J.,

concurring and quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976).)[3]

Connolly, in fact, specifically endorsed the principle relied on by petitioners here, that the "purpose of forbidding uncompensated takings of private property for public use is 'to bar Government from forcing some people alone to bear public burdens which, in fairness and justice should be borne by the public as a whole.' " *Id.* at 227, *quoting Armstrong v. United States*, 364 U.S. 40, 49 (1960).

Specifically, this Court in *Connolly* determined that it was neither unjust nor unfair to require employers withdrawing from multi-employer pension plans to pay over to the plans the employer's proportionate share of "unfunded vested benefits." 475 U.S. at 227. The Court suggested that employers generally were the source of the social evil to be remedied by virtue of their practice of "unregulated withdrawals from multiemployer plans [which] could endanger [the plans'] financial vitality and deprive workers of the vested rights they were entitled to anticipate would be theirs upon retirement." *Id.* at 227.

Moreover, the Court found the employers in that litigation voluntarily negotiated and maintained a pension plan which was later determined to be within the strictures of ERISA. *Id.*

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[3] Respondents assert that the fee caps do not "unduly interfere with any of petitioners' reasonable, investment-backed expectations" since "health care is a pervasively regulated field," and Congress has regulated physician fees to Medicare patients since 1984. Resp. Br. p. 9. However, the petitioners had no reason to expect the *permanent* compulsory cap on their fees imposed by the present act, since the two prior fee limitations were both, by their terms, temporary restrictions. (*See* Pet. App. A-4; 42 U.S.C. § 1395u(j) (1)(B).) Furthermore, respondents' contention has no applicability in the instant case, which as noted below, is governed by cases dealing with public utilities. *See, e.g. Colorado Springs Credit Association v. Farm Credit Administration*, 967 F.2d 648, 656, n. 8 (D.C. Cir. 1992) ("In this era of pervasive regulation, this factor might prove far too much: almost any entity could be said to have a reasonable expectation of governmental intrusion. If the existence of regulation were critical to takings claims, the long-established principle that a public utility has had its property taken if its rates are set too low would appear rather dubious. *See, e.g., Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307-08, 109 S.CT. 609, 615, 102 L.Ed.2d 646 (1989).")

Thus, there is a sharp distinction between *Connolly* and this case, in which petitioners 1) *must* treat Medicare patients and do not voluntarily subject themselves to the fee caps, and 2) are not the cause of the inability of some Medicare patients to pay fair market rates for medical services.

Since the petitioners are not the source of the social evil to be remedied, the fee caps amount to a taking, under the logic of Justice Scalia's separate opinion in *Pennell*. 485 U.S. at 20.

The Court of Appeals for the Second Circuit recognized that the Scalia opinion in *Pennell* was "appealing," but found that "[u]ntil Justice Scalia's view is adopted by a majority of the Court, this taking theory must fail." (Pet. App. A-11.) This case warrants review as a vehicle to test whether the view of Justice Scalia in *Pennell* will prevail in the case of physicians who are compelled to render their services at government dictated prices. *See also* the District Court's Opinion to the effect that:

> Justice Scalia's analysis of the takings claim . . . has considerable logical force and may foreshadow a future shift in Supreme Court jurisprudence. . . .
>
> (Pet. App. B-12.)

Similarly, the decision in *Concrete Pipe & Products of California, Inc. v. Construction Laborers Pension Trust For Southern California*, 113 S.Ct. 2264 (1993), cited by respondents for the principle that a diminution in value cannot equal a taking, is not controlling in this case. First, *Concrete Pipe* dealt with the same statutory scheme as that at issue in the *Connolly* case and is thus inapplicable here, where the anesthesiologists are not the source of the social evil to be remedied.

Moreover, *Concrete Pipe* dealt with a one-time taking in the form of 46% of shareholder equity of plaintiff employer. *See* 113 S.Ct. at 2291. The instant case, in contrast, deals with *permanent* price regulation imposed on a *compulsory service*. Therefore, the decisions governing this case are those pertaining to regulation of public utility rates. *See, e.g., Duquesne v. Barasch*, 488 U.S. 299 (1989). (*See* Pet. p. 13.) Respondents fail even to address this crucial distinction.

The utility cases hold that failure to pay reasonable compensation for mandated utility services is a taking of property without just compensation in violation of the Fifth Amendment: *See Duquesne*, 488 U.S. at 307-308; *see also Minnesota Association of Health Care Facilities, Inc.*, 742 F.2d at 446.

At one time, utility cases employed a "fair value rule" which was based on the value of the utility's assets and sought to "mimic the operation of the competitive market." *Duquesne*, 488 U.S. at 308. Later decisions varied from this method because:

> the exchange value of a utility's assets, such as powerplants, could not be set by a market price because such assets were rarely bought and sold. Nor could the capital assets be valued by the stream of income they produced because setting that stream of income was the very object of the rate proceeding. (*Id.* at 309.)

In the instant case, however, the market value of the taken service is readily ascertainable — i.e. the physicians' actual charge to private patients — and there is no reason to depart from the standard fair market measure of reasonable compensation.

The fee caps which limit petitioners to 28% of market value (see *supra* Par. B(5)) are therefore unreasonable and confiscatory and constitute a taking in violation of the Fifth Amendment.

Finally, to the extent that *Concrete Pipe* conflicts with the long standing utility cases, certiorari should be granted to clarify the state of the law in this regard.

CONCLUSION

Accordingly, we pray that the petition for certiorari be granted.

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